# *Chapter 1 - What's New?*
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## *A. What's New?*

This chapter of the Guidebook overviews "What's New" in the Emergency Management Program (EMP) including standards, regulations, directives, grant opportunities and important Veterans Health Administration (VHA) resource materials. Of particular interest in the 2009 edition of the Guidebook is updated Joint Commission materials and the FY 2008 National Incident Management System (NIMS) Compliance Objectives. For further information on compliance with The Joint Commission, National Incident Management System, National Fire Protection Association (NFPA), and Continuity Programs see Enclosure 1-3, Crosswalk of VHA Emergency Management Program Guidebook Steps to Relevant Standards.

1. *The Joint Commission (TJC)*. The 2009 revision of TJC Standards, effective January 1, 2009, created a stand alone chapter for the Emergency Management (EM) standards. The Joint Comission's stated intent of the stand alone chapter is to offer improved organization, clarity, and reinforce an organization wide priority and effort to EM. The 2009 EM chapter contains no new expectations although some standards read differently due to clarification or were moved into the EM chapter. The Joint Commission continues to focus on an all-hazards approach, maintaining an Emergency Operations Plan (EOP), monitoring key areas during an emergency, and evaluation of the planning process and the EOP. TJC encourages organizations to use a "scalable: approach". This approach combination can enable the VHA to manage a variety of disasters even if the disaster escalates in intensity, complexity, scope, or duration. The EMP Guidebook provides guidance and examples for compliance with The Joint Commission Standards.

   Standards EC.4.11 through EC.4.20 are no longer found in the Environment of Care chapter; they moved and were reorganized and renumbered in the EM chapter. The EM chapter has standards EM.01.01.01 to EM.03.01.03 and multiple Elements of Performance (EP) for each standard. Check with the Quality Management Office at your facility regarding to TJC Standards.

   Outline of the New EM chapter (as provided in the beginning of TJC's EM chapter):

   I. Foundation for the Plan (EM.01.01.01)

   II. The Plan for Emergency Response

      A. General Requirements (EM.02.01.01)

      B. Specific Requirements

1. Communications (EM.02.02.01)
2. Resources and Assets (EM.02.02.03)
3. Security and Safety (EM.02.02.03)
4. Staff (EM.02.02.07)
5. Utilities (EM.02.02.09)
6. Patients (EM.02.02.11)
7. Disaster Volunteer
    a. Volunteer Licensed Independent Practitioners (EM.02.02.13)
    b. Volunteer Practitioners (EM.02.02.15)

III. Evaluation

A. Evaluating the Planning Activities (EM.03.01.01)

B. Evaluating the Plan through Exercises (EM.03.01.03)

EM.01.01.01 - Foundation for the plan includes planning activities such as the Emergency Management Committee, Hazard Vulnerability Analysis, Community Partnership, and inventory documentation. Thus begins the process of refining program requirements by defining risks and mobilizing an effective response. This process becomes the foundation for the Emergency Operations Plan.

EM.02.01.01 - Developing and maintaining an Emergency Operations Plan covers minimum elements for an "all hazards" EOP. Comprehensive Emergency Operations Plan development is covered in Chapter 4.

EM.02.02.01 - EM.02.02.11 - Based on The Joint Commission's objective for Healthcare Organizations to provide care, treatment, and services for an extended length of time during emergencies. This objective, in combination with reviews of recent emergency aftermaths, prompted TJC to identify six critical functions that require management regardless of the cause or causes of an emergency. The VHA cannot predict the nature of a future emergency, nor can it predict the date of its arrival. However, all medical centers can plan for managing these areas. Compliance Tips can be found in Section B of this chapter. Cross referencing the 2009 Joint Commission Standards with the Sample SOPs is addressed in Section E of Chapter 6,Step 4: Incident-Specific Plans. Incident-Specific Planning provides introductions, relevant policies, commentary on operations during extended emergencies in detail, and provides guidance on how the topics might be addressed in the future. Incident-Specific Plans and Preparedness and Mitigation Plans have been updated in this Guidebook to meet regulatory needs.

EM.02.02.13 and EM.02.02.15 - Standards previously in The Joint Commission's Medical Staff Chapter that define the processes for accepting disaster volunteers have

been added to the EM chapter for both licensed independent practitioners and volunteer practitioners who are not licensed independent practitioners, but who are required by law and regulation to have a license, certificate, or registration.

EM.03.01.01 - Evaluation of the planning activities now includes conducting an annual review of its inventory process and documentation of the findings.

EM.03.01.03 - The effectiveness of the EOP is primarily conducted by exercises and responses to emergency situations. During exercises it is important to test the ability to respond to the effects of emergencies on the VHA mission and capability to provide care, treatment and services.

*Additional information on exercises and exercise design are included in Chapter 9, Step 7: Education, Training and Exercises*.

2. *Standard on Disaster/Emergency Management and Business Continuity Programs 2007 Edition*. The NFPA Standard 1600 or through NFPA Codes Online at) establishes a common set of criteria for disaster/emergency management and business continuity programs. The 2007 edition incorporates changes to the 2004 edition, expanding the conceptual framework for disaster/emergency management and business continuity programs. Previous editions of the standard focused on the four aspects of mitigation, preparedness, response and recovery. Additionally, the 2007 edition identifies prevention as a distinct aspect of the program. Doing so brings the standard into alignment with related disciplines and practices of risk management, security, and loss prevention.

3. *Management of Domestic Incidents - Homeland Security Presidential Directive (HSPD)-5*. Released in February 2003, called for the Secretary of Homeland Security to develop and administer the NIMS and the National Response Plan (now known as the National Response Framework).

    a. NIMS established a uniform approach to incident management for federal, state, and local governments, and mandated its adoption beginning in Fiscal Year 2005. In June 2008, the Incident Management Systems Integration (IMSI) and Department of Health and Human Services (HHS) announced the release of the *FY 2008 and 2009 NIMS Implementation Objectives for Healthcare Organizations.* There are fourteen healthcare objectives intended for all hospitals regardless of size, location, or financial support. The fourteen objectives span Adoption, Preparedness Planning, Preparedness Training and Exercise, Communication and Information Management and Command and Management. The compliance due date is August 8, 2009. A Crosswalk for Compliance with the various elements of NIMS is provided (see Enclosure 1-3). NIMS can be downloaded at

    b. The National Response Framework (NRF) established a comprehensive, national, all-hazards approach to domestic incident response (requirement under HSPD-5). The NRF builds upon the previous National Response Plan and incorporates elements from the Federal Radiological Emergency Response Plan, National Contingency Plan and an interagency terrorism concept of operations plan. The Framework incorporates public and private-sector participation at all levels, from

federal agencies to the state and community level, and also emphasizes the importance of personal preparedness by individuals and their families The document was published in January, 2008. VA has responsibilities in the NRF (see Chapter 8 of this Guidebook for more information on these).

4. *Critical Infrastructure Identification, Prioritization, and Protection (HSPD-7)*. Released in December 2003, HSPD-7 established a national policy for federal departments and agencies to identify and prioritize United States critical infrastructure and key resources (CI/KR) and to protect them from terrorist attacks including an emphasis on critical infrastructure and key resources that could be exploited to cause catastrophic health effects or mass casualties comparable to those from the use of a weapon of mass destruction. Implementation of this work shall be consistent with the Homeland Security Act of 2002. The abstract and full text of *HSPD-7* is posted on the Homeland Security website at 5. *National Preparedness (HSPD-8)*. Released in December 2003, HSPD-8 established policies to strengthen the preparedness of the United States to prevent and respond to threatened or actual domestic terrorist attacks, major disaster, and other emergencies by requiring a national domestic all-hazards preparedness goal, establishing mechanisms for improved delivery of federal preparedness assistance to state and local governments, and outlining actions to strengthen preparedness capabilities for Federal, State, and local entities. This directive is a companion to HSPD-5, which identifies steps for improved coordination in response to incidents. The abstract and full text of *HSPD-8* is posted on the Homeland Security website at

6. *Pandemic and All-Hazards Preparedness Act (PAHPA), Public Law No. 109-417*. Signed in December 2006, PAHPA established a new Assistant Secretary for Preparedness and Response (ASPR) within the Department of Health and Human Services (HHS) and provided new authorities for a number of programs, including the advanced development and acquisition of medical countermeasures, and called for the establishment of a quadrennial National Health Security Strategy. One of the eight major program areas under PAHPA is grants. HHS was authorized by legislation to award competitive grants or cooperative agreements (CA) to eligible entities to enable such entities to improve and continue to strengthen healthcare medical surge capacity and to develop or improve the following five sub-capabilities: interoperable communication system, bed tracking system, Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) system, fatality management plans and hospital evacuation plans, aimed to enhance community, and hospital preparedness for public health emergencies. PAHPA transferred the National Bioterrorism Hospital Preparedness Program (NBHPP) from Health Resources and Services Administration (HRSA) to ASPR. ASPR funds are awarded through the Hospital Preparedness Program (HPP). To date, funding was provided for both 2007 and 2008. For further information, including the applicable Public Laws, log onto

7. *National Continuity Policy National Security Presidential Directive (NSPD)-51/HSPD-20*. This policy addresses a comprehensive continuity policy for the Federal Government and builds on Federal Emergency Management Agency's (FEMA) Federal Preparedness Circular 65 (FPC 65), June 15, 2004. The new guidance, entitled Federal Continuity Directive 1, Federal Executive Branch, National Continuity Program,

November 6, 2007, provides mandatory guidance to Federal Executive Departments and Agencies in developing contingency plans and programs for continuity of operations (COOP) plans and procedures. COOP planning facilitates the performance of department/agency essential functions following the disruption of normal operations. An important part of COOP planning is the selection, as appropriate, of an alternate operation facility and the provisioning of interoperable communications with all essential internal and external organizations, customers and the public. COOP plans are a subset of the organization's EOP, and are incorporated within this Guidebook. Sample COOP plans are provided on the Emergency Management Program Guidebook CD

8. *National Strategy for Public Health and Medical Preparedness (HSPD-21)*. An important and commendable development in national biodefense policy, HSPD-21 specifically addresses preparedness for catastrophic health events, which are defined as "any natural or manmade incident, including terrorism, that results in a number of ill or injured persons sufficient to overwhelm the capabilities of immediate local and regional emergency response and health care systems."

9. *Comprehensive Emergency Management Program (CEMP) VHA Directive 0320*. This directive defines an "all hazards" CEMP and incorporates guidance for compliance with standards and regulations. The directive also established a policy level committee with a core group referred to as the VHACO Emergency Management Coordination Group (EMCG). The core group is comprised of Health and Operation (10N), Public Health and Environmental Hazards (13), Patient Care Services (11) and Nursing (108). The core group is supported by six subcommittees focused on medical and public health, Disaster Emergency Medical Personnel System (DEMPS), resources, education, training and exercise, continuity of operations, and Emergency Management Program evaluation.

10. *"Emergency Management: Principles and Practice for Healthcare Systems*." Released in June 2006, this is an educational curriculum developed under contract by the Veterans Health Administration. The texts are organized into five units: The Emergency Management Program, Incident Command System, Healthcare System Emergency Response and Recovery, Emergency Management Instruction, System Evaluation and Organizational Learning, and the Appendices. The curriculum strives to enhance management expertise within healthcare organizations to operate effectively as both individual resources and as integrated participants in the larger emergency response community.

11. *Emergency Management Academy*. This training tool is comprised of three interactive web-based courses. The first course titled "Introduction to Emergency Management Programs for Healthcare Systems" provides foundation knowledge. The second course, and of particular interest to use with this Guidebook, is the "Emergency Management Program Development" unit. This unit is designed to teach development of an effective Emergency Management Program. A third course has just been completed and teaches the Incident Management System. These courses are available on VA Learning Online.

12. *VHA Capability Assessment Program*. In 2007, leadership within VHA wanted an assessment of the operational readiness of hospitals, Network Offices and Central

Office. To design its assessment methodology, VHA began with the generic priorities of any organization in emergency response and recovery: incident management; occupant safety; continuity of operations (resiliency); expansion of service (surge); and support to external requirements. These priorities were used to group activities commonly seen in emergencies as "emergency operations capabilities." A set of "program level capabilities" necessary to develop, maintain, and evaluate the emergency operations capabilities were also articulated.

Two separate Steering Committees were formed to assist in the design and refinement of the methodology. The first group, an internal VHA group, included physicians, engineers, hospital and VISN administrators, safety officers, and emergency managers. The second group consisted of representatives from other federal agencies including Health and Human Services (ASPR and Agency for Healthcare Research and Quality , AHRQ), Homeland Security (Other Federal Agency, OFA), and Department of Defense (Health Affairs).

The "Capability Assessment Program" integrates all existing external and VHA emergency management-related standards and doctrine into one formative evaluation methodology. The protocol includes a pre-survey, a standardized site visit agenda and interview questions, scoring tool, and blends key disciplines (hospital administration, clinical, technical, and emergency management expertise) into an Assessment Team that uses a combination of assessment methods. The protocol took advantage of lessons learned from the Institute of Medicine (IOM) and Emergency Management Accreditation Program (EMAP) experiences and placed a high emphasis on creating an environment that emphasized collaboration and learning.

Information on the VHA Capability Assessment Program Capability Descriptions can be found in Annex A of the VHA Comprehensive Emergency Management Program Capability Assessor's Guide. .

## *B. Compliance Tips*

The VHA cannot predict the nature of a future emergency, nor can it predict the date of its arrival. However, all of our medical centers can plan for supporting key areas that might be affected by emergencies of different causes. Key areas of Emergency Management are:

- Communications
- Resources and Assets
- Safety and Security
- Staff Responsibilities
- Utilities Management
- Patient Clinical and Support Activities

1. **Communication (EM.02.02.01)**.

    a. As leaders in healthcare in any community, the public expects hospitals to be informed of the risks and aware if and when an emergency occurs. Hospitals conduct ongoing active surveillance within the organization. When an emergency is

detected, there are provisions for communicating with the patient, families, and staff as well as communication and collaboration with outside facilities and other healthcare organizations and support. In an emergency that extends into a mass casualty incident (MCI), it is particularly essential that hospitals work with public health officials, other government officials, neighboring healthcare facilities, the lay public, and the press to ensure rapid and ongoing communications (information-sharing) occurs.

b. The organization plans for notifying staff when emergency response measures are initiated should include:

- Assign responsibility for staff notification when an emergency occurs and response measures are initiated.
- Consider investment in most reliable communications systems, ensure good maintenance and repair, and have several back-ups.
- Establish redundant systems for communication.
- Consider sendwordnow system (system that sends an alert e-mail, cell phone, and landline notification at one time).
- Evaluate the use of Clinical Warnings, Alerts and Directives (CWAD) system for staff notification.
- Identify points of contact among local media (e.g., newspaper, radio, television) representatives to report alert information and actions for hospital staff to take.

c. External Communication:

- Assign responsibility for external communication; identify persons responsible for updating public health reporting (e.g., infection control), a clinical spokesperson (e.g., Medical Director or Nurse Executive), and a media spokesperson (e.g., Public Information's Officer).
- With guidance from VHA, VISN, state or local health departments, determine the methods, frequency, and scope of external communications.
- Identify points of contact among local media (e.g., newspaper, radio, television) representatives, public officials, and community leaders.
- Develop and test a ring-down system between facilities in the community.
- Develop and test operating unit templates for communication systems failure.
- Develop plan for monitoring and reporting of outages, consequences, and interim communication methods.
- Consider use of cell phones, e-mail, couriers, satellite phones, blackberries, and radios.

d. Things to consider:

- *Within VA*: If the VHA facility is made aware of a threat/event or if one occurs, whom within VA should be notified?
- *Other Federal Agencies*: Depending on the threat/event, certain federal agencies (FEMA, HHS, OSHA, Centers for Disease Control, EPA) may need to be notified. For example, OSHA is to be notified within eight hours of one employee fatality, or three employee hospitalizations resulting from a single incident.

- *Community Entities*: Because of the VA Medical Center's relationship to the community, it is likely that there are specific entities within the community that should be notified that a threat/event has occurred. In many cases, this notification will trigger a community response to the threat/event.

2. **Resources and Assets (EM.02.02.03)**.

   a. Medical, pharmaceutical, and non-medical supplies that will be required at the onset of an emergency response should be available to support operations for up to 96 hours without replenishment from outside sources.

      - Plans should be developed for replenishing medical and non-medical supplies and equipment, including personal protective equipment (PPE), for the duration of the response and recovery period. Plans should take into account that the circumstances of the emergency situation may be such that local replenishment options might not be available for an extended period of time.
      - Plans should be developed for replenishing pharmaceutical supplies needed for the response and recovery period. Sources may include cache stockpiles, either VA-owned or available through local, state, or other federal sources.
      - Plans should be developed for supporting direct staff needs, such as housing, transportation, and incident stress debriefings. Indirect staff support needs, such as child/elder care, should also be addressed.
      - Other potential sources of resources and assets, such as local and regional healthcare organizations, should be explored and included in plans as appropriate.
      - Plans should be developed for facility evacuation. These plans should address transportation of patients, patient information, staff, and equipment to an alternative care site in the event that a total evacuation is required.

   b. Additional information on potential sources for resources and assets during an emergency situation may be found in Chapter 8, *Step 6: External Coordination and Mutual Support*.

3. **Safety and Security (EM.02.02.05)**.

   - The first source of additional security personnel would be other VA facilities in the VISN, due to familiarity with VA police procedures. The same principle applies to Occupational Safety and Health professionals. If travel difficulties prevent the use of outside VA employees, extended hours for local VA employees is a viable alternative.
   - Extended emergencies could require community support from local law enforcement, contract security agencies, or the National Guard.
   - There is a need for heightened awareness concerning facility access control, as the circumstances that cause extended emergencies present opportunities for malefactors to take advantage of the disturbances in normal operations.
   - At the beginning of each workday during an extended emergency, as well as other regular and frequent intervals, inspect the interior and exterior of buildings for suspicious packages. Staff should check their own work areas, as they will be most familiar with something that is out-of-place or suspicious in nature. VA Police,

Environmental Management Service, and Facilities Engineering should concentrate on public/common areas.

- Review security alert levels and taskings with the police forces responsible for security at the local facility.
- Ensure operational testing of building security plans and alarms, particularly the lockdown procedure. The heightened perils of extended emergencies call for assurances that alarms (such as panic alarms and fire alarms) and doors that automatically lock are acting as they should. These should be checked during each shift of the extended emergency. If deficiencies are encountered, repairs should be made. If repairs cannot be made immediately, increased patrols or permanently placing a person in the area of the malfunctioning piece of equipment should be considered. Such a person must be capable of monitoring the piece of equipment and summoning aid as required. There is no need to place a uniformed officer in the role of a watchman.
- The Chief of Police Service must be familiar with law enforcement officials in the community at every level of government, in case there is a need for outside assistance during an extended emergency.
- The Chief of Occupational Health and Safety must also be involved in the community in case the skill set of a safety professional is needed during an extended emergency to keep the medical center open and functioning in a satisfactory manner.
- The Hazardous Materials Management Plan should be reviewed to establish the manpower requirements to keep the collection process for hazardous waste on schedule and not allow a collection of waste to accumulate.
- The Medical Center's policy on wandering patients should be reviewed to ensure alarms and door looks are operating properly in areas where patients who are wandering risks are concentrated.
- Vehicular traffic into the medical center should be controlled on a vehicle-by-vehicle basis for the duration of the extended emergency. Vehicles not readily identifiable as one operated by VA employee should be stopped and questioned.

4. **Managing Staff Responsibilities (EM.02.02.07)**.

   a. Surge Capacity. Healthcare facilities should plan ahead to address emergency staffing needs and possible increased demands for isolation wards, Intensive Care Units, assisted ventilation services, and consumable and durable medical equipment/supply needs.

   b. Staff Planning for Extended MCI (96 hours).

      - Assign responsibility for the assessment and coordination of staffing during an emergency.
      - Estimate the number and categories of personnel needed to care for a patient or group of patients with injuries or illness (depending on the type of MCI and care needed) for a given day.
      - Plan to provide local support within the facility or at the community level for up to 96 hours, without outside assistance.

- Determine how the facility will meet staffing needs as the number of patients increase and/or as healthcare workers become ill or stay home with ill family members. Consider:
  - Assigning patient care responsibilities to clinical administrators.
  - Recruiting retired healthcare personnel.
  - Using training staff (e.g., medical and nursing students).
  - Using patients' families or other volunteers in an ancillary healthcare capacity (e.g., pass water, change linens, visit with patients).
- Collaborate with local and regional healthcare planning groups in an attempt to achieve adequate staffing of the hospital during an MCI (e.g., decide if and how staff-sharing will occur between healthcare facilities, determine how salary issues will be addressed for shared employees, consider ways to increase the number of home healthcare staff to reduce the number of admissions during the emergency).
- State and local health departments can help assess the feasibility of recruiting staff from different hospitals and/or regions, working in coordination with federal facilities, including the Veterans Administration and Department of Defense hospitals. Healthcare facilities may implement these arrangements through Mutual Aid Agreements (MAA) or Memorandum of Understanding/Agreements (MOU/A).
- Increase cross training of personnel to provide support for essential patient care areas at times of severe staffing shortages (e.g., Emergency Departments, ICUs, or medical units).
- Identify essential support personnel critical in an MCI.

c. Staff are trained for their assigned roles and responsibilities in an MCI.

- Identify roles and responsibilities of staff positions that are deemed critical in an MCI.
- Provide ongoing education and training for specific job requirements.
- Consider all facility healthcare personnel for awareness level training.
- Personnel whose role would include donning PPE above the level D rating must complete operations level training in accordance with OSHA directives.
- Identify specific job action sheets, checklist or flow charts for specific roles, to be used at the time of an MCI. (Reference Enclosure 4-4, VHA Incident Management System Position Descriptions.)
- Provide just-in-time training for specific roles when an MCI occurs and as additional staff fill roles during the MCI event.

d. The organization communicates to the Licensed Independent Practitioners (LIP) their roles in emergency response, and to whom they report during an emergent situation.

- Develop a plan for communication with LIPs regarding their role in the facility and/or community, and who they report to during an MCI.
- Consider all healthcare personnel for awareness level training.

- Personnel whose role would include donning PPE above the level D rating must complete operations level training IAW OSHA directives.
- Identify job action sheets, checklist and/or flow charts for LIP specific roles, to be used at the time of an MCI.
- Provide just-in-time training for specific roles when an MCI occurs, and as additional staff change shifts to fill roles during the MCI event.
- Provide on-going education and updates regarding the facility's and community's Emergency Operations Plan.
- Consult with the state health department on plans for rapidly credentialing healthcare professionals during an MCI. This might include defining when an "emergency staffing crisis" can be declared, and identifying emergency laws that allow employment of healthcare personnel with out-of-state licenses.
- Identify insurance and liability issues related to the use of non-facility staff.
- Explore opportunities for recruiting healthcare personnel from other healthcare settings (e.g., medical offices, psychiatric hospitals or clinics, and day-surgery centers). Consult public health partners about existing state or local personnel.

e. The organization establishes a process for identifying healthcare providers and other personnel assigned to particular areas during an emergency.

- Consult with the state and local health departments, police departments, etc., on plans for developing standardized facility/community identification for critical personnel in an MCI, such as identification cards, wristbands, vests, hats, badges, computer or computer printouts. This might include defining when an "emergency staffing crisis" can be declared, and identifying emergency laws that would require staff to use such an identifier to get through traffic, a barricade or an otherwise restricted area.

5. **Utilities (EM.02.02.09).**

   The elements of performance associated with EM.02.02.09 require that organizations identify an alternate means of providing for the following utilities in the event that their supply is compromised or disrupted:

   - Electricity.
   - Water needed for consumption and essential care activities.
   - Water needed for equipment and sanitary purposes.
   - Fuel required for building operations or essential transport activities.
   - Other essential utility needs (for example, ventilation, medical gas/vacuum systems, etc.).

   These requirements can be viewed as an extension of Joint Commission standards EC.01.01.01 and EC.02.05.01 requiring hospitals to manage utility risks. As part of this standard, facilities will have previously conducted assessments of every utility system at their facility and determined which of those utility systems are "*essential*." In addition, facilities will have already identified alternate sources for hospital-defined essential utilities in meeting the elements of performance for EC.01.01.01 and EC.02.05.01. Organizations should thoroughly review the elements of performance of EC.01.01.01 and EC.02.05.01, and the work already completed to comply with that standard as a basis for developing the strategies required by EM.02.02.09. The additional requirements demand that a healthcare organization communicates with its community about facility needs, and the community can help meet those needs.

   Additionally, the following Joint Commission standards also address Utility Management, and should be reviewed by the organization to identify plans, Standard Operating Procedures and policies developed that may help to meet EM.02.02.09:

   Organizations should determine how long they expect to remain open to care for patients and plan for their utilities accordingly. In addition, they must address how they will continue operations without community support for up to 96 hours. It is important to realize that an appropriate response may involve closing or evacuating the healthcare organization after a certain period. For example, an organization may determine that it can be self-sufficient during an emergency for 48 hours after which point it will initiate evacuation procedures. However, the organization must also make sure that its evacuation plan can be supported 48 hours after the start of an emergency.

6. **Patient Clinical and Support Activities during an Emergency (EM.02.02.11)**

   - The Pharmaceutical Cache can only be used with the permission of the Medical Center Director.
   - Patient scheduling is built around several variables that are quantifiable only when the extent of the disaster is known. In general, any elective or non-emergency procedure should be postponed until the emergency is over.

- Clinical personnel freed up by cancelling elective or non-emergency procedures should be reassigned to areas where their talents could be used in other clinical situations.
- Altered standards of care, once approved by clinical superiors, should be implemented as required by either the large number of patients or the reduced number of clinicians. The type of altered standards and when the standard should be implemented are to be decided by the Chief of Staff of the medical center. Altered standards of care are defined as steps to reduce the amount of time spent with an individual patient, use of clinically trained support personnel in non-traditional roles, and increased use of palliative care only for the most severely injured. Visitors and family could be pressed into service under the supervision/guidance of the clinical staff. Employees can be reassigned from areas where the workload has changed to more direct support roles such as nutrition or environmental management. No employee should be forced to take part in a new position, but rewards can be extended to employees who volunteer during extended emergencies.
- Hygiene needs of employees should be addressed by issuing small containers of anti-bacterial cleaners and identifying expanded employee shower areas.
- If required by the conditions of the emergency, employees should be offered PPE when around patients.
- Counselors should be upgraded to a level of knowledge about the conditions of the emergency as soon as the conditions are known. Counselors might be put into unfamiliar roles, depending on the number of patients, families, and employees in need of some form of counseling, to be of service to the hospital community. Any resident clergy should also be offered training.
- The medical center should coordinate with the local coroner's office to address how the coroner's office will handle the increased patient load and how mortuary affairs will be handled with the potential increase of deceased.
- Palliative care of victims of the emergency will require tracking of the patients' condition, disposition, and custody of personal effects.

## *C. Enclosures*

1-1. Emergency Management Crosswalk 2008-2009.

1-2. The Joint Commission Crosswalk 2008-2009.

1-3. Crosswalk of VHA Emergency Management Program Guidebook Steps to Relevant Standards.